Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Dr. Charles A. Wallace 17110 Dallas N. Pkwy, Suite 100 Dallas, TX 75248	MFDR Tracking #:	M4-10-1291-01
Respondent Name and Box #: TEXAS MUTUAL INSURANCE CO. Box #: 54		

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

The Requestor did not submit a position statement.

Principle Documentation:

1. DWC 060
2. Medical Bill and EOBs
3. Operative report
4. Total Amount Sought $3,805.00

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary, dated November 23, 2009, states in part, "…Texas Mutual reviewed the bill and attached documentation, concluded the services required preauthorization, and declined to issue payment because further review reflected there was no emergency related to the surgery…."

Principle Documentation:

1. DWC 060 Response

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
05/01/2007	CAC-18, CAC-197, 878, 930, CAC-50 and 244	26746-Open treatment of articular fracture, involving metacarpophalangeal or interphalangeal joint, includes internal fixation, when performed, each 26418-Repair, extensor tendon, finger, primary or secondary; without free graft, each tendon 11760-Repair of nail bed 11044-Debridement; skin, subcutaneous tissue, muscle, and bone	$3,805.00	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

1. These services were denied by the Respondent with reason codes:
   - CAC-18-Duplicate claim/service
   - CAC-197- Precertification/authorization/notification absent
   - 878-Duplicate appeal request medial dispute resolution through DWC for continued disagreement of original appeal decision
   - 930-pre-authorization required. Reimbursement denied.
   - CAC-50-These are non-covered services because this I not deemed a medical necessity by the payer.
   - 244-Unnecessary medical

2. The Division has raised issues in order to administer the dispute process consistent with the provisions of the Labor Code and Division rules. The 28 TAC Section 133.307(e)(2), states, "…The Division will review the completed request and response to determine appropriate MDR action….The Division may raise issues in the MDR process when it determines such an action to be appropriate to administer the dispute process consistent with the provisions of the Labor Code and Division rules."
3. Medical Fee Dispute Resolution (MFDR) received the DWC 060 on October 27, 2009. The date of service in dispute is May 1, 2007. Rule 133.307 (c) (1)(A), states, "(c) Requests. Requests for medical dispute resolution (MDR) shall be filed in the form and manner prescribed by the Division. Requestors shall file two legible copies of the request with the Division. (1) Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The dispute was filed after the one year filing deadline.
4. The Division concludes that this dispute is not eligible for review due to the untimely filing of the MDR request. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
Rule 133.307

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §413.031, the Division has determined that the Requestor is entitled to $0.00 reimbursement.

		December 3, 2009
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.